

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64559

4604 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>HAVRE DE GRACE</u>		LENGTH OF STAY (In this place) <u>30 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		TOWN <u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>315 GIRARD ST.</u>				STREET ADDRESS (If rural give location) <u>1 315 GIRARD ST</u>			
3. NAME OF DECEASED (Type or Print) <u>ANNIE</u> (First) <u>ALLEN</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 18</u> 19 <u>60</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JAN. 15, 1878</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>N. D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>HARFORD CO. WELFARE BELAIR MD.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>						<u>15 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Occlusion</u>						<u>1 hour</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Myocarditis with Hypertension</u>						<u>15 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>April</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 18</u> , 19 <u>60</u> , and that death occurred at <u>4:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John Welch</u> M.D.				ADDRESS (Street, city, town, state) <u>HAVRE DE GRACE</u>		DATE SIGNED <u>April 19, 1960</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4-21-1960</u>		NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>		LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD.</u>	
24. REC'D BY REGISTRAR DATE <u>APR 22 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>HAVRE DE GRACE MD.</u>	

210112001218

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Manner of death: [illegible]
6. Signature of physician: [illegible]
7. Signature of registrar: [illegible]
8. Date of registration: [illegible]

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 11

Reg. Div. 11a

1. Name of deceased		2. Date of death		3. Place of death	
4. Cause of death		5. Manner of death		6. Signature of physician	
7. Signature of registrar		8. Date of registration		9. [illegible]	
10. [illegible]		11. [illegible]		12. [illegible]	
13. [illegible]		14. [illegible]		15. [illegible]	
16. [illegible]		17. [illegible]		18. [illegible]	
19. [illegible]		20. [illegible]		21. [illegible]	
22. [illegible]		23. [illegible]		24. [illegible]	
25. [illegible]		26. [illegible]		27. [illegible]	
28. [illegible]		29. [illegible]		30. [illegible]	
31. [illegible]		32. [illegible]		33. [illegible]	
34. [illegible]		35. [illegible]		36. [illegible]	
37. [illegible]		38. [illegible]		39. [illegible]	
40. [illegible]		41. [illegible]		42. [illegible]	
43. [illegible]		44. [illegible]		45. [illegible]	
46. [illegible]		47. [illegible]		48. [illegible]	
49. [illegible]		50. [illegible]		51. [illegible]	
52. [illegible]		53. [illegible]		54. [illegible]	
55. [illegible]		56. [illegible]		57. [illegible]	
58. [illegible]		59. [illegible]		60. [illegible]	
61. [illegible]		62. [illegible]		63. [illegible]	
64. [illegible]		65. [illegible]		66. [illegible]	
67. [illegible]		68. [illegible]		69. [illegible]	
70. [illegible]		71. [illegible]		72. [illegible]	
73. [illegible]		74. [illegible]		75. [illegible]	
76. [illegible]		77. [illegible]		78. [illegible]	
79. [illegible]		80. [illegible]		81. [illegible]	
82. [illegible]		83. [illegible]		84. [illegible]	
85. [illegible]		86. [illegible]		87. [illegible]	
88. [illegible]		89. [illegible]		90. [illegible]	
91. [illegible]		92. [illegible]		93. [illegible]	
94. [illegible]		95. [illegible]		96. [illegible]	
97. [illegible]		98. [illegible]		99. [illegible]	
100. [illegible]		101. [illegible]		102. [illegible]	

4605

CERTIFICATE OF DEATH

Reg. Dist. No.

64560

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Forest Hill</u>				d. STREET ADDRESS <u>Grier Nursery Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SABIE</u> Middle <u>MAY</u> Last <u>BLACK</u>				4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 20, 1888</u>	
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u> Hours <u>12</u> Min.		IF UNDER 24 HRS. Months <u>7</u> Days <u>12</u> Hours <u>12</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JAMES BLACK HALL</u>				14. MOTHER'S MAIDEN NAME <u>JESTINE BURRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>INFORMANT Husband - Mr. John F. Black</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac DeCompensation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive and Arteriosclerotic</u> DUE TO (c) <u>Cardiovascular disease</u> Pneumonitis INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>> 1 year</u>				18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Harford</u> (County) <u>Harford</u> (State) <u>Md.</u>							
21. I certify that I attended the deceased from <u>April 12th, 1960</u> to <u>April 12, 1960</u> that I last saw the deceased alive on <u>April 12th, 1960</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>				ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Harford Co., Maryland</u>			
DATE SIGNED <u>4/12/60</u>							
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				<u>Harford Co., Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>April 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>BEL AIR, Harford Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>				ADDRESS <u>W. Broadway + William St. BEL AIR, Maryland</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hanna</u>	
DATE <u>APR 18 '60</u>				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64561

4621

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barlington</u>		c. LENGTH OF STAY IN 1b <u>34 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Emanuel</u> Last <u>Bostic</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 23, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph F Bostic</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Major</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>214-15-6309</u>	
17. INFORMANT <u>Wm Bostic</u>		Address <u>Barlington Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Condition</u> DUE TO (b) <u>Natural</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>✓</u>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>✓ 19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 8, 1960</u> to <u>April 13, 1960</u> , that (I) (we) last saw the deceased alive on <u>April 12, 1960</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>F.P. Snodgrass</u>		22b. DATE, SIGNED <u>4/14/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>F.P. Snodgrass</u>		22d. ADDRESS <u>Barlington Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>April 15, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Barlington Cm</u>	23d. LOCATION (City, town, or county) (State) <u>Harford Co Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Art. Bailey</u>		25. REC'D BY REGISTRAR <u>APR 20 '60</u>	
ADDRESS <u>Barlington, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

CERTIFICATE OF DEATH

1951

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4606

CERTIFICATE OF DEATH

64562

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 HRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE</u> <u>Boyd</u>		4. DATE OF DEATH Month Day Year <u>April</u> <u>22</u> <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-14-66</u>
9a. AGE (In years last birthday) yrs. <u>94</u>		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Famous</u>		14. MOTHER'S MAIDEN NAME <u>MARY CARR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>ALVIN BOYD, STREET, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemorrhage from</u> DUE TO (c) <u>Carcinoma of JAW</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MARCH</u> , 19 <u>54</u> , to <u>April 22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>APRIL 22</u> , 19 <u>60</u> , and that death occurred at <u>1230 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips</u>		DATE SIGNED <u>4/22/60</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>		ADDRESS (Street, city or town, state) <u>Darlington, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-25-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EMONY</u>	22d. LOCATION (City, town, or county) (State) <u>STREET, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins, Delta, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 26 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knecht</u>

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington Rural</u>				c. LENGTH OF STAY IN 1b <u>14 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stafford Road</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CORNELIA</u> Middle <u>T.</u> Last <u>CAMERON</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 5, 1864</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Joseph Tilford</u>				14. MOTHER'S MAIDEN NAME <u>Cornelia DEAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Mrs. Buckner M. Creel</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>794X</u> DUE TO <u>Old Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____				20g. (County) _____		20h. (State) _____	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>57</u> , to <u>APRIL 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>APRIL 15</u> , 19 <u>60</u> , and that death occurred at <u>7 PM</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dudley Phillips MD</u>				ADDRESS (Street, city or town, state) <u>Darlington, Md</u>			
DATE SIGNED _____							
PHYSICIAN'S NAME (Type) <u>Darlington, Md</u>				<u>Dudley Phillips MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 22, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>				ADDRESS <u>W. Broadway + Williams St. BEL Air, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 22 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Form No. 1

1. Name of deceased (Print or write full name)

2. Date of death

3. Sex of deceased

4. Age at death

5. Race of deceased

6. Place of birth

7. Usual residence at time of death

8. Cause of death

9. Duration of illness

10. Name of physician

11. Name of attending nurse

12. Name of informant

13. Signature of informant

14. Signature of physician

15. Signature of registrar

16. Date of registration

17. Place of death

18. Name of hospital

19. Name of attending physician

20. Name of attending nurse

21. Name of attending physician

22. Name of attending nurse

23. Name of attending physician

24. Name of attending nurse

25. Name of attending physician

26. Name of attending nurse

27. Name of attending physician

28. Name of attending nurse

29. Name of attending physician

30. Name of attending nurse

31. Name of attending physician

32. Name of attending nurse

33. Name of attending physician

34. Name of attending nurse

35. Name of attending physician

36. Name of attending nurse

37. Name of attending physician

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44. Name of attending nurse

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51. Name of attending physician

52. Name of attending nurse

53. Name of attending physician

54. Name of attending nurse

55. Name of attending physician

56. Name of attending nurse

57. Name of attending physician

58. Name of attending nurse

59. Name of attending physician

60. Name of attending nurse

61. Name of attending physician

62. Name of attending nurse

63. Name of attending physician

64. Name of attending nurse

65. Name of attending physician

66. Name of attending nurse

67. Name of attending physician

68. Name of attending nurse

69. Name of attending physician

70. Name of attending nurse

71. Name of attending physician

72. Name of attending nurse

4607

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>8 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARGUERITE</u> Middle <u>INEZ</u> Last <u>CARTER</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 2, 1960</u>	
9. AGE (In years last birthday) yrs. <u>8</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN N. CARTER JR.</u>				14. MOTHER'S MAIDEN NAME <u>FELICIA CARTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT <u>Mr. John N. Carter, Jr. 119 Hawthorne Dr. Edgewood, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Meningitis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>4-2</u> , 19 <u>60</u> , to <u>4-11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-11</u> , 19 <u>60</u> , and that death occurred at <u>2:44</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>St Louis Pahan</u>				ADDRESS (Street, city or town, state) <u>Box 966 Edgewood Md</u>			
DATE SIGNED <u>4/11/60</u>				PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-13-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Darlington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Claris J. Bullock, Haure de Grace, Md.</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>APR 14 '60</u>				2071321XV4			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7545

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4601 CERTIFICATE OF DEATH

64566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford County Home, Toll Gate Rd., Bel Air</u>		d. STREET ADDRESS <u>47X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Davis</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 4, 1873</u>
9. AGE (In years lost birthday) yrs. <u>86</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Clark E. Fitzpatrick, Toll Gate Rd., Bel Air, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Thrombosis, </u> DUE TO (b) <u> </u> DUE TO (c) <u>Chronic cardio-vascular disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>?</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Jan. 2</u> , 19 <u>40</u> , to <u>April 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>60</u> , and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>April 19, 1960</u>			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Md.</u> <u>April 19, 1960</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>4-19-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore 12, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		24a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
VS A15 (4) 15M 10/57		DATE <u>APR 22 '60</u>	

4602

~~MEDICAL EXAMINER'S~~ CERTIFICATE OF DEATH

04567

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford County Almshouse</u>				d. STREET ADDRESS <u>Harford County Almshouse</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Dimong</u> Last <u></u>				4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 2, 1872</u>		9. AGE (in years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ice & Fish</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>William Dimong</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>John A. Dimong, 3759 N. 10th St., Phila., Pa.,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>4-12-60</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 13, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard S. McCombs Jr</u>				ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BATHING
CERTIFICATE OF DEATH

450.0

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF SHERIFF		SIGNATURE OF SORCERER		SIGNATURE OF OTHER																															
John A. Smith		45		Male		White		Roman Catholic		Married		High School		Teacher		Boston, Mass.		July 1, 1912		Boston, Mass.		Heart Disease		Natural		John A. Smith		John B. Smith		John C. Smith		John D. Smith		John E. Smith		John F. Smith		John G. Smith		John H. Smith		John I. Smith		John J. Smith		John K. Smith		John L. Smith		John M. Smith		John N. Smith		John O. Smith		John P. Smith		John Q. Smith		John R. Smith		John S. Smith		John T. Smith		John U. Smith		John V. Smith		John W. Smith		John X. Smith		John Y. Smith		John Z. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4608

CERTIFICATE OF DEATH

64568

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLORA, Rural</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE BELL FOGLEMAN</u>				4. DATE OF DEATH Month Day Year <u>April 12 1960</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-19-1884</u>		9. AGE (In years last birthday) <u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES R. PATRICK</u>				14. MOTHER'S MAIDEN NAME <u>JALLIE HESS</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-14-1767</u>		17. INFORMANT Address <u>Mrs John L. Madron Colora, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophageal Varices</u> <u>294X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Polycthemia Vera</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 yrs.</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/2</u> , 19 <u>60</u> , to <u>4/22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/22</u> , 19 <u>60</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Rising Sun, Md</u> <u>4/14/60</u>									
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.		PHYSICIAN'S NAME (Type) <u>Neil Taylor</u> M.D. <u>Rising Sun, Md</u> <u>4/14/60</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-16-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem.</u>		22d. LOCATION (City, town, or county) <u>Conowingo</u> (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Theron E. McMullen</u>				ADDRESS <u>Rising Sun Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

14621

4623

CERTIFICATE OF DEATH

64569

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FALLSTON</u>				c. LENGTH OF STAY IN 1b <u>1 Month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FALLSTON Road</u>				d. STREET ADDRESS <u>1 FALLSTON Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>SADIE</u> First <u>JOHNSON</u> Middle <u>GARDNER</u> Last				4. DATE OF DEATH Month <u>APRIL</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 5, 1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>New York City</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ALEXANDER JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>(UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>MILDRED WILLINGHAM (daughter)</u>				Address <u>FALLSTON, ME.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL Thrombosis</u> <u>332 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 or 6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension ; Old fracture of left hip, with non-union (5 yrs ago)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>MARCH 22, 1960</u> , to <u>APRIL 15, 1960</u> , that I last saw the deceased alive on <u>APRIL 15, 1960</u> , and that death occurred at <u>7:25 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul S. Stonesifer Jr.</u>				M.D. <u>115 FULFORD AVE.</u>		DATE SIGNED <u>APRIL 15 1960</u>	
PHYSICIAN'S NAME (Type) <u>PAUL S. STONESIFER JR.</u>				ADDRESS (Street, city or town, state) <u>BEL AIR, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harpurville</u>		22d. LOCATION (City, town, or county) (State) <u>Harpurville N. Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Parryson M. Howard Chau. Md</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 19 1960</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fink</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

XLFE

M. B. O. M. P.

<p>NAME OF DECEASED [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>AGE [Faint text]</p>		<p>SEX [Faint text]</p>	
<p>PLACE OF BIRTH [Faint text]</p>		<p>DATE OF BIRTH [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>	
<p>DATE OF DEATH [Faint text]</p>		<p>TIME OF DEATH [Faint text]</p>	
<p>NAME OF PHYSICIAN [Faint text]</p>		<p>NAME OF REGISTRAR [Faint text]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>SIGNATURE OF REGISTRAR [Faint text]</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEATH REGISTRATION ACT, 1953.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4624

CERTIFICATE OF DEATH

64570

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford		c. LENGTH OF STAY IN 1b 67 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WARREN Middle CRANMER Last GLASGOW		4. DATE OF DEATH Month April Day 6 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1892
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto	
11. BIRTHPLACE (State or foreign country) Delta, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E. Glasgow		14. MOTHER'S MAIDEN NAME Dollie LaRue	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-32-7629	
17. INFORMANT Mildred Glasgow, Whiteford, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 5, 1960 to April 6, 1960 , that I last saw the deceased alive on April 5, 1960 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph A. Hunt M.D.		ADDRESS (Street, city or town, state) Delta, Pa. DATE SIGNED 4/7/60	
PHYSICIAN'S NAME (Type) Josiah A. Hunt			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 9, 1960	22c. NAME OF CEMETERY OR CREMATORY Slate Ridge	22d. LOCATION (City, town, or county) (State) Delta, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins ADDRESS Delta, Penna.		24a. REC'D BY REGISTRAR APR 11 '60 DATE	24b. REGISTRAR'S SIGNATURE Livingston L. Hunt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4625

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 1 Yr 9 Mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hospital Aberdeen Proving Ground, Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle B. Last HANCOCK SR		4. DATE OF DEATH Month April Day 2 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 December 1915
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Army		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick T Hancock Sr		14. MOTHER'S MAIDEN NAME Margaret Ann Bradley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Robert B. Hancock Jr		Address RFD #3 Aberdeen, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of Myocardium DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 13 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 March , 1960, to 2 April , 1960, that I last saw the deceased alive on 1 April , 1960, and that death occurred at 7:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph A Grossman M.D.		DATE SIGNED 2 April '60 USAH 2 Apr 60	
PHYSICIAN'S NAME (Type) JOSEPH A GROSSMAN Capt MC		ADDRESS (Street, city or town, state) Aberdeen Proving Ground, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 4-4-60	22c. NAME OF CEMETERY OR CREMATORY Pawtucket	22d. LOCATION (City, town, or county) (State) Pawtucket, Rhode Island.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. 6009 Harford Rd. (14)		24a. REC'D BY REGISTRAR APR 5 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4626 CERTIFICATE OF DEATH

64572
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Valentine G. Hartman</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4, 1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operating Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.,</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>				13. FATHER'S NAME <u>Valentine Hartman</u>			
14. MOTHER'S MAIDEN NAME <u>Bertha Hannock</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>212-26-0497</u>				17. INFORMANT Address <u>Mrs., Regina A. Hartman, Joppa, Md.,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Atherosclerotic C-V Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>4 yrs</u> <u>6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				20g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>Sept 4, 1960</u> to <u>April 19, 1960</u> , that I lost saw the deceased alive on <u>April 3, 1960</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Churchville, Maryland</u> DATE SIGNED <u>Apr. 19, 1960</u>							
ACTUAL SIGNATURE <u>J. Ralph Horky</u>				M.D. <u>Churchville, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>J. Ralph Horky</u>				<u>Churchville, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 22, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens</u>		22d. LOCATION (City, town, or county) (State) <u>Bradshaw, Balto., Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs</u>				ADDRESS <u>Abingdon, Md.,</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>				24c. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

12. Name of informant: [illegible]
13. Address of informant: [illegible]
14. Signature of informant: [illegible]
15. Date of completion: [illegible]

16. Name of registrar: [illegible]
17. Signature of registrar: [illegible]
18. Date of registration: [illegible]

19. Name of informant: [illegible]
20. Address of informant: [illegible]
21. Signature of informant: [illegible]
22. Date of completion: [illegible]

23. Name of registrar: [illegible]
24. Signature of registrar: [illegible]
25. Date of registration: [illegible]

26. Name of informant: [illegible]
27. Address of informant: [illegible]
28. Signature of informant: [illegible]
29. Date of completion: [illegible]

30. Name of registrar: [illegible]
31. Signature of registrar: [illegible]
32. Date of registration: [illegible]

33. Name of informant: [illegible]
34. Address of informant: [illegible]
35. Signature of informant: [illegible]
36. Date of completion: [illegible]

37. Name of registrar: [illegible]
38. Signature of registrar: [illegible]
39. Date of registration: [illegible]

40. Name of informant: [illegible]
41. Address of informant: [illegible]
42. Signature of informant: [illegible]
43. Date of completion: [illegible]

44. Name of registrar: [illegible]
45. Signature of registrar: [illegible]
46. Date of registration: [illegible]

47. Name of informant: [illegible]
48. Address of informant: [illegible]
49. Signature of informant: [illegible]
50. Date of completion: [illegible]

51. Name of registrar: [illegible]
52. Signature of registrar: [illegible]
53. Date of registration: [illegible]

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4627 **CERTIFICATE OF DEATH**

64573

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland COUNTY Harford			
CITY (If outside corporate limits, write RURAL OR end give nearest town) Forest Hill		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Forest Hill			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Alice		(Middle) M.		(Last) Hess			
				April 26 1960			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH May 21, 1879	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bristol, England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Sly				14. MOTHER'S MAIDEN NAME Marguerite Chamberlain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 417-38-4574		17. INFORMANT & ADDRESS Arthur Hess, 111 Greenbrier Rd. Towson 4			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH 20 hours			
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic C-V-D				prob. 15 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/25/60 , 19....., to 4/26/60 , 19....., that I last saw the deceased alive on 4/26/60 , 19....., and that death occurred at 8:46 AM , from the causes and on the date stated above.							
SIGNATURE Robert Barth M.D.				ADDRESS (Street, city, town, state) Forest Hill, Maryland		DATE SIGNED 4/26/60	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		DATE THEREOF 4-28-60		NAME OF CEMETERY OR CREMATORY Green Mount		LOCATION (City, town, or county) (State) Baltimore	
24. REC'D BY REGISTRAR APR 28 60		REGISTRAR'S SIGNATURE Caroline A. Moore		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Cook-Towson, Inc., 1050 York Road ZONE 4			

4609

CERTIFICATE OF DEATH

04574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>				c. LENGTH OF STAY IN 1b <u>8 days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Mem. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cyrus</u> Middle <u>Eugene</u> Last <u>Hill</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/20/89</u>	9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(ret'd) Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City Highways</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Cyrus Hill</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Cochran</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W.I</u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u>			
17. ADDRESS <u>Mrs. Charles Laird Bel Air, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia, right</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>lower lobe.</u> DUE TO DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis and left hemiplegia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour <u>a.m.</u> Month <u>19</u> Day <u>19</u> Year <u>1960</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 12th, 1960</u> to <u>April 20th, 1960</u> that I last saw the deceased alive on <u>April 20th, 1960</u> and that death occurred at <u>1:05 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Lee, M.D.</u>				ADDRESS (Street, city or town, state) <u>241 N. Union Ave. Md.</u>			
DATE SIGNED <u>4/20/60</u>							
PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>				<u>Harve de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-23-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Taylor Ave & Dalesford Road</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>APR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

17

18

Handwritten text, mostly illegible due to fading and bleed-through. Visible fragments include:
- "I hereby certify that on the 17th day of May 1901"
- "at the residence of the deceased"
- "John Doe"
- "aged 45 years"
- "of the County of ... State of ..."
- "Signed and sealed in presence of"
- "Witnesses"
- "The undersigned"
- "Minister of the Gospel"
- "Pastor of the ... Church"
- "at ... on the 17th day of May 1901"

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
4628 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 64576

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania b. COUNTY Blair ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Altoona 75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 266 Everett Road				d. STREET ADDRESS 518 16th Street.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RALPH WILLIAM HORNER				4. DATE OF DEATH Month Day Year April 24, 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1897	
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Penn. RR		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Centre Co., Pennsylvania	
13. FATHER'S NAME Calvin Horner				14. MOTHER'S MAIDEN NAME Carrie Glass			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease complicated by aspirated stomach contents Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Peter W. Rieckert				CHIEF MEDICAL EXAMINER <input type="checkbox"/> Medical Investigator <input checked="" type="checkbox"/> DATE SIGNED 4/25/60			
EXAMINER'S NAME (Type) Peter Rieckert, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4/25/60		22c. NAME OF CEMETERY OR CREMATORY Alto Rest Burial Cem.		22d. LOCATION (City, town, or country) (State) Altoona, Pennsylvania	
23. FUNERAL DIRECTOR Wm. Cook - Blight, Inc. 6009 Harford Road				24a. REC'D BY REGISTRAR DATE APR 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION



1933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

Attest: [illegible]
[illegible]

1933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4611
CERTIFICATE OF DEATH

04577

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>	c. LENGTH OF STAY IN 1b <u>about 30 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harve de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Elizabeth Street</u>		d. STREET ADDRESS <u>1 Elizabeth Street</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rudolph C. James</u>		4. DATE OF DEATH Month Day Year <u>4 27 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22, 1916</u>
9. AGE (In years lost birthday) <u>44 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware Store</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John James</u>	
14. MOTHER'S MAIDEN NAME <u>Carrie Powell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>717-09-8297</u>		17. INFORMANT Address <u>Mr. Elsworth James Harve de Grace, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH <u>5 minute</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> 19 <u>60</u> to <u>4/27</u> 19 <u>60</u> that (I) (we) lost the deceased alive on <u>4/27</u> 19 <u>60</u> and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman Berger</u>		22b. DATE SIGNED <u>4/27/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Norman Berger</u>		22d. ADDRESS <u>200 N-Union Ave Harve de Grace, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/30/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Darlington, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Atelis Bullock - Harve de Grace, Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 2 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. Krause</u>			

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of _____

City of _____

State of _____

Decedent's Name _____

Age _____

Sex _____

Marital Status _____

Occupation _____

Place of Birth _____

Date of Death _____

Time of Death _____

Place of Death _____

Cause of Death _____

Signature of Physician _____

Signature of Coroner _____

Signature of Registrar _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

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Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04578

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamden</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hennietta Davis Jay</u>		4. DATE OF DEATH <u>April 30</u> 19 <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-90</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Smith Jay</u>		14. MOTHER'S MAIDEN NAME <u>Annie Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mrs. J. Merryman Black</u>		Address <u>Cockeysville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma stomach</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-30-60</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-2-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spoustasia</u>		22d. LOCATION (City, town, or county) (State) <u>Perryman, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons, Inc. 1900 Rutaw Place</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 3 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED J. D. ALLEN, JR.		2. PLACE OF BIRTH BALTIMORE, MARYLAND	
3. DATE OF DEATH JAN 15, 1950		4. TIME OF DEATH 10:30 AM	
5. SEX MALE		6. AGE 45	
7. OCCUPATION DRIVER		8. CAUSE OF DEATH HEART DISEASE	
9. MANNER OF DEATH NATURAL		10. SIGNATURE OF EXAMINER J. D. ALLEN, JR.	
11. SIGNATURE OF WITNESS J. D. ALLEN, JR.		12. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
13. SIGNATURE OF WITNESS J. D. ALLEN, JR.		14. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
15. SIGNATURE OF WITNESS J. D. ALLEN, JR.		16. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
17. SIGNATURE OF WITNESS J. D. ALLEN, JR.		18. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
19. SIGNATURE OF WITNESS J. D. ALLEN, JR.		20. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
21. SIGNATURE OF WITNESS J. D. ALLEN, JR.		22. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
23. SIGNATURE OF WITNESS J. D. ALLEN, JR.		24. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
25. SIGNATURE OF WITNESS J. D. ALLEN, JR.		26. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
27. SIGNATURE OF WITNESS J. D. ALLEN, JR.		28. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
29. SIGNATURE OF WITNESS J. D. ALLEN, JR.		30. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
31. SIGNATURE OF WITNESS J. D. ALLEN, JR.		32. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
33. SIGNATURE OF WITNESS J. D. ALLEN, JR.		34. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
35. SIGNATURE OF WITNESS J. D. ALLEN, JR.		36. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
37. SIGNATURE OF WITNESS J. D. ALLEN, JR.		38. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
39. SIGNATURE OF WITNESS J. D. ALLEN, JR.		40. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
41. SIGNATURE OF WITNESS J. D. ALLEN, JR.		42. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
43. SIGNATURE OF WITNESS J. D. ALLEN, JR.		44. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
45. SIGNATURE OF WITNESS J. D. ALLEN, JR.		46. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
47. SIGNATURE OF WITNESS J. D. ALLEN, JR.		48. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
49. SIGNATURE OF WITNESS J. D. ALLEN, JR.		50. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
51. SIGNATURE OF WITNESS J. D. ALLEN, JR.		52. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
53. SIGNATURE OF WITNESS J. D. ALLEN, JR.		54. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
55. SIGNATURE OF WITNESS J. D. ALLEN, JR.		56. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
57. SIGNATURE OF WITNESS J. D. ALLEN, JR.		58. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
59. SIGNATURE OF WITNESS J. D. ALLEN, JR.		60. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
61. SIGNATURE OF WITNESS J. D. ALLEN, JR.		62. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
63. SIGNATURE OF WITNESS J. D. ALLEN, JR.		64. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
65. SIGNATURE OF WITNESS J. D. ALLEN, JR.		66. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
67. SIGNATURE OF WITNESS J. D. ALLEN, JR.		68. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
69. SIGNATURE OF WITNESS J. D. ALLEN, JR.		70. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
71. SIGNATURE OF WITNESS J. D. ALLEN, JR.		72. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
73. SIGNATURE OF WITNESS J. D. ALLEN, JR.		74. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
75. SIGNATURE OF WITNESS J. D. ALLEN, JR.		76. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
77. SIGNATURE OF WITNESS J. D. ALLEN, JR.		78. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
79. SIGNATURE OF WITNESS J. D. ALLEN, JR.		80. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
81. SIGNATURE OF WITNESS J. D. ALLEN, JR.		82. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
83. SIGNATURE OF WITNESS J. D. ALLEN, JR.		84. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
85. SIGNATURE OF WITNESS J. D. ALLEN, JR.		86. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
87. SIGNATURE OF WITNESS J. D. ALLEN, JR.		88. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
89. SIGNATURE OF WITNESS J. D. ALLEN, JR.		90. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
91. SIGNATURE OF WITNESS J. D. ALLEN, JR.		92. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
93. SIGNATURE OF WITNESS J. D. ALLEN, JR.		94. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
95. SIGNATURE OF WITNESS J. D. ALLEN, JR.		96. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
97. SIGNATURE OF WITNESS J. D. ALLEN, JR.		98. SIGNATURE OF WITNESS J. D. ALLEN, JR.	
99. SIGNATURE OF WITNESS J. D. ALLEN, JR.		100. SIGNATURE OF WITNESS J. D. ALLEN, JR.	

4629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 64579

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MD Rte 165</u>		d. STREET ADDRESS <u>Whiteford</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Thomas Jones</u> First Middle Last		4. DATE OF DEATH <u>April 16</u> Month Day Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 1, 1936</u>
9. AGE (In years last birthday) <u>23</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>CUMBERLAND, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES W. JONES</u>		14. MOTHER'S MAIDEN NAME <u>MARGIE S. MOYER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>215-34-1108</u>	
17. INFORMANT <u>CHARLES W. JONES, WHITEFORD, MD.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>819X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto acc., auto-object type</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4-15-60</u> <u>1130</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MD Rte 165</u>	20f. (City or town) <u>Street Harford</u> (County) <u>MD</u> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-19-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>		22d. LOCATION (City, town, or county) <u>DELTA, PA</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harbison, Delta, Pa.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>APR 19 1960</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles P. Jones</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8/19X

DICTIONARY MATRIMONIAL

Form with multiple sections for medical examination and death certification, including fields for name, date, time, and cause of death. The form is partially filled out with handwritten text.

NAME: John Doe
DATE: 8/19/88
TIME: 10:00 AM
CAUSE OF DEATH: Heart Disease

Additional fields include: PLACE OF DEATH, SEX, AGE, OCCUPATION, and SIGNATURE.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your notes.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4630 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04580

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>street</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MD Route 165</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Donald Edward Jones</u>		4. DATE OF DEATH <u>April 16</u> 19 <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 8, 1938</u>
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. MARINE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>CUMBERLAND, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES W. JONES</u>		14. MOTHER'S MAIDEN NAME <u>MARGIE S. MOYER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES 1955-1960</u>		16. SOCIAL SECURITY NO. <u>219-34-0323</u>	
17. INFORMANT <u>CHARLES W. JONES, WHITEFORD, MD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 819X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto - object type</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>1130</u> p. m. <u>4-15-60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 165</u>		20f. (City or town) <u>Street Harford</u> (County) <u>MD</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>MD</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-16-60</u>	
22a. BURIAL CREMATION: <u>BURIAL</u>		22b. DATE THEREOF <u>4-19-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>		22d. LOCATION (City, town, or county) <u>DELTA, PA.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins, Delta, Pa.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>APR 19 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harkins</u>	

819X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4612

CERTIFICATE OF DEATH

64581

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lifetime</u> <u>734 Otsegr Street</u>		d. STREET ADDRESS <u>734 Otsegr Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edmond</u> Middle <u>L</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1890</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Common Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Harre de Grace, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Jones</u>		14. MOTHER'S MAIDEN NAME <u>Celestia Bowser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>220-032483</u>	
17. INFORMANT <u>Mrs. William Jones</u>		Address <u>738 Otsegr St. Harre de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u>Hypertensive Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/12</u> , 19 <u>59</u> , to <u>4/20</u> , 19 <u>60</u> ; that I last saw the deceased alive on <u>4/20</u> , 19 <u>60</u> , and that death occurred at <u>2:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>509 Revolution St. Harre de Grace, Md.</u>	
DATE SIGNED <u>4/21/60</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-23-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harre de Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullock</u>		ADDRESS <u>Harre de Grace, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

4631

CERTIFICATE OF DEATH

64582

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Stanley Knopp</u>		4. DATE OF DEATH Month Day Year <u>April 19, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Boyd</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Lottie Mohr Catonsville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 2, 1951</u> to <u>April 19, 1960</u> , that I last saw the deceased alive on <u>April 15, 1960</u> , and that death occurred at <u>5:15 a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Forest Hill, Md. April 19, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/22/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>William Watters</u>	22d. LOCATION (City, town, or county) (State) <u>Cooptown Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Furtz</u>		ADDRESS <u>Jarrettsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles C. Furtz</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4632

CERTIFICATE OF DEATH

Reg. Dist. No.

4583

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>				c. LENGTH OF STAY IN 1b <u>38 yrs.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Pine Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Heinrich</u> <u>Kolmar</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>3</u> Year <u>19 60</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 24, 1885</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchmaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturer</u>				11. BIRTHPLACE (State or foreign country) <u>Sag Harbor, N.Y.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Emanuel Shapiro</u>		Address <u>Edgewood Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure, Ectopic, nodular</u> <u>723.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Osteoarthritis, Hip Bilateral</u> (c) <u></u>												4. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Edgewood</u>		(County) (State)			
21. I certify that I attended the deceased from <u>3/15</u> , 19 <u>60</u> , to <u>3/20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/20</u> , 19 <u>60</u> , and that death occurred at <u>P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Box 966 Edgewood Md</u> DATE SIGNED <u>4/4/60</u> ACTUAL SIGNATURE <u>E. Louis Kahan</u> M.D. PHYSICIAN'S NAME (Type) <u>E. Louis Kahan</u> <u>Edgewood Maryland</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Apr. 6, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCombs Jr</u>						ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		1912	
Age		Sex	
35		Male	
Place of Birth		Cause of Death	
Maryland		Heart Disease	
Occupation		Duration of Illness	
Teacher		3 weeks	
Signature of Physician		Signature of Registrar	
J. A. Smith		W. B. Jones	
Date of Signature		Date of Signature	
1912		1912	

14
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Item 18-29-60 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
64584											
1. PLACE OF DEATH a. COUNTY Harford MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Street				c. LENGTH OF STAY IN 1b U. S. Route 1				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middle River			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Route 1						d. STREET ADDRESS 24 Cockpit Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY G. MARSH						4. DATE OF DEATH April 11 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-15-1893		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Aircraft				11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Marsh				14. MOTHER'S MAIDEN NAME Victoria Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) I				16. SOCIAL SECURITY NO. 189-09-7048A		17. INFORMANT Address Mrs Harry Marsh 24 Cockpit Street					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale DUE TO 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Bronchial Asthma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
2Dc. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) 12		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/12/60											
ACTUAL SIGNATURE Charles S. Petty				M.D. Charles S. Petty, M.D.				Address (Street, city, town, or county) Lancaster Pa.			
EXAMINER'S NAME (Type) Charles S. Petty, M.D.				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-14-1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Cemetery	
23. FUNERAL DIRECTOR Lassahn Funeral Home				ADDRESS 7401 Belair Road				24a. REC'D BY REGISTRAR DATE APR 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. House	

1
FOR THE
UNITED STATES
NAVY
OFFICE OF THE
CHIEF OF MEDICAL
DEPARTMENT

1

NAVY AND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible]
PLACE OF EXAMINATION: [illegible]

EXAMINER'S SIGNATURE: [illegible]
TITLE: [illegible]

WITNESSES: [illegible]
DATE: [illegible]

PLACE: [illegible]

REMARKS: [illegible]

DATE: [illegible]

PLACE: [illegible]

DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

4634

64585

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAVRE DE GRACE				c. LENGTH OF STAY IN 1b 5 MO.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. Star Route				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATE Middle VAN LIEW Last MATTOON				4. DATE OF DEATH Month APRIL Day 28 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 5, 1876	9. AGE (In years last birthday) yrs. 83	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDSON VAN LIEW				14. MOTHER'S MAIDEN NAME MARY SUNDERLIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Mr. Fred R. Cordua, HAVRE DE GRACE, STARROUTE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARDIAC DECOMPENSATION DUE TO (c) 1 YEAR						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1959 to 4-28 , 1960, that (I) (we) last saw the deceased alive on 4-28 , 1960, and that death occurred on 5-1 , 1960, from the causes and on the date stated above.							
22a. SIGNATURE GUNTHER D. HIRSCH				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-29-60	
22c. PHYSICIAN'S NAME (Type) GUNTHER D. HIRSCH				22d. ADDRESS 803 Giles ST. HAVRE DE GRACE			
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF MAY 2, 1960		23c. NAME OF CEMETERY OR CREMATORY LODON PARK CEM.		23d. LOCATION (City, town, or county) (State) BALTIMORE MD.	
24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell				ADDRESS HAVRE DE GRACE MD		25a. REC'D BY REGISTRAR MAY 3 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

CERTIFICATE OF DEATH

1902

1902

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
John Doe		45		Male		White		White		Roman Catholic		Married		Farmer		Heart Disease		Home		Jan 15 1902		10:00 AM		J. Smith		A. Jones		B. Brown	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4635

64586

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Havre de Grace	
d. NAME OF HOSPITAL (If not in hospital, give street address) US Army Hospital Aberdeen Proving Ground, Md				d. STREET ADDRESS 243 Bloomsbury Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle ALFERD Last MEYER				4. DATE OF DEATH Month April Day 12 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1960		9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alferd Meyer				14. MOTHER'S MAIDEN NAME Edna Earle Harrell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Mother		Address 243 Bloomsbury Avenue Havre de Grace, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory distress syndrome 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.</p> <p>(b) Congenital anomalies of GU tract and possibly intestinal tract</p> <p>(c)</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH 11 hrs 15 min</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from 11 April 19 60 to 12 April 19 60 , that (I) was last saw the deceased alive on 12 April 19 60 and that death occurred 8:30AM from the causes and on the date stated above.							
22a. SIGNATURE <i>Thomas J Fraher</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12 Apr 60	
22c. PHYSICIAN'S NAME (Type) THOMAS J FRAHER Capt MC				22d. ADDRESS US Army Hospital Aberdeen Proving Ground, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 4/13/60		23c. NAME OF CEMETERY OR CREMATORY Angel Hill		23d. LOCATION (City, town, or county) (State) Harford County Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington & Son</i>				25a. REC'D BY REGISTRAR DATE APR 18 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frazer</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

2050301XV6

756.2

4613

CERTIFICATE OF DEATH

64587
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvey, de Grace</u>		c. LENGTH OF STAY IN 1b <u>Am. 4-27-60</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Pacholik</u> Last <u>Pacholik</u>		4. DATE OF DEATH <u>April 30</u> 19 <u>60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8, 1870</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailor</u>	
11. BIRTHPLACE (State or foreign country) <u>Europe (Czech)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Frank A Pacholik - son - same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Empyema, left</u> DUE TO <u>Bronchopneumonia, left</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 days</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>O.A.S.C.V.D. (2) Bleeding hemorrhoid</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/27</u> , 19 <u>60</u> , to <u>4/30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/30</u> , 19 <u>60</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D.		ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Harford de Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		DATE SIGNED <u>4/30/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 3, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23a. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCune Jr</u>		23b. ADDRESS <u>Abingdon, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Jan. 8, 1974

(Cause)

Unknown

Unknown

None

X

Signature

Signature

Signature

Location, etc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4614

CERTIFICATE OF DEATH

Reg. Dist. No.

04588

1. PLACE OF DEATH a. COUNTY <u>Harford Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harold Chase</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harold Chase</u>		24			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>1000 Chesapeake Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jason</u> Middle <u>J.</u> Last <u>Pate</u>				4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/18/1915</u>			
9. AGE (In years lost birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Chesapeake Regulating Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Montezuma, Ga.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Samuel Y. Pate</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Franklin</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Virginia L. Pate</u> Address <u>1000 Chesapeake Drive, Harold Chase, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u> DUE TO (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month <u>—</u> Day <u>—</u> Year <u>19</u> Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work <u>—</u> Not while <input type="checkbox"/> of work <u>—</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/23rd</u> , 19 <u>60</u> , to <u>4/2nd</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/2nd</u> , 19 <u>60</u> , and that death occurred at <u>10:10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>211 North Union Avenue</u> DATE SIGNED <u>4/4/60</u>									
ACTUAL SIGNATURE <u>Edward C. Lee</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Edward C. Lee</u> <u>Havre de Grace, Maryland</u>					
22. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u>		22b. DATE THEREOF <u>4/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bellin Memorial Chapel, Bel Air, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u>				ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '60</u>			
				24b. REGISTRAR'S SIGNATURE <u>—</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4636

CERTIFICATE OF DEATH

64589

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR RURAL</u>		c. LENGTH OF STAY IN 1b <u>14 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Churchville Road</u>		d. STREET ADDRESS <u>1 Churchville Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>R.</u> Last <u>PETERS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4, 1877</u>
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Floyd County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Moses Peters</u>		14. MOTHER'S MAIDEN NAME <u>RD. #2 Elizabeth Trusler Bel Air, Md.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-24-9967</u>	
17. INFORMANT <u>Mrs. Zula E. Thomas Peters</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> <u>clauemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>CVA</u> DUE TO (c) <u>arteriosclerosis - essent. hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>N/A</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>10 days</u> <u>sev. yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>N/A</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>31 Mar</u> , 19 <u>60</u> , to <u>31 Mar</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>31 MAR</u> , 19 <u>60</u> , and that death occurred at <u>5:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>115 Juleford Ave, Bel Air, Md.</u> DATE SIGNED <u>4/14/60</u>			
ACTUAL SIGNATURE <u>Warren R. Lesch, M.D.</u> M.D. <u>115 Juleford Ave, Bel Air, Md.</u>		DATE SIGNED <u>4/14/60</u>	
PHYSICIAN'S NAME (Type) <u>WARREN R. LESCH, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 5, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air RD., Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Truter</u> ADDRESS <u>W. Broadway & Williams St. BEL Air, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

CERTIFICATE OF DEATH

WILLIAM BOHND
JAN 10 1924

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
WILLIAM BOHND		M		38		JAN 10 1886		SEATTLE, WASH.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
SEATTLE, WASH.		LABORER		HEART DISEASE		NATURAL		SEATTLE, WASH.	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 10 1924		10:30 AM		10:30		30		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF ENTRY		TIME OF ENTRY		HOUR OF ENTRY		MINUTE OF ENTRY		SECOND OF ENTRY	
JAN 10 1924		10:30 AM		10:30		30		00	

4615

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64590

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. Y.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn 59</u> 69X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>871 Fox St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Melvin Schwartz</u>		4. DATE OF DEATH Month Day Year <u>April 1 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/1937</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>22</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Clumbing</u>	
11c. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julius Schwartz</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Podrid</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Charles Albert</u>		Address <u>115 W. 79th St. New York</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 815X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>815X</u> (c), stating the underlying cause last. DUE TO (c) <u>815X</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Motorcycle accident with m.v.</u>	
20c. TIME OF INJURY Hour a. m. <u>4</u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rte 40</u>	20f. (City or town) (County) (State) <u>Nr. Edward Harf. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D. CHIEF MEDICAL EXAMINER <u>Beltin, Md.</u> DATE SIGNED <u>4-1-60</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/3/60</u>	22b. DATE THEREOF <u>4/3/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sharon Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>New York N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donington R. R. Harde</u> ADDRESS <u>Harde</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	24b. REGISTRAR'S SIGNATURE <u>James S. Hines</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Edgewood, 25 Starr St.,</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>April</u> , Day <u>9</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 25, 1959</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>John L. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. Dillon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>John L. Smith</u>		Address <u>Edgewood Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of Foreign Body</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Brucella pneumonia</u> DUE TO (c) <u>Cerebral Palsy</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/6</u> , 19 <u>60</u> , to <u>4/8</u> , 19 <u>60</u> ; that I last saw the deceased alive on <u>4/8</u> , 19 <u>60</u> , and that death occurred at <u>11 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Edgewood Maryland.</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>E. Louis Kahan</u> M.D.		PHYSICIAN'S NAME (Type) <u>E. Louis Kahan</u> <u>Edgewood Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 11, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chokesbury Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.,</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Brown</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

401K

4616

CERTIFICATE OF DEATH

64593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. LENGTH OF STAY IN 1b <u>7 days.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>				X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Mem. Hosp.</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Preston</u> Last <u>Smithson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/84</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Smithson</u>				14. MOTHER'S MAIDEN NAME <u>Sophia ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
INFORMANT <u>Oliyer Boyer</u>				Address <u>Forest Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myeloid Leukemia, Aleukemic stage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus and A.S.C.V.D. Incurable</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>April</u> Day <u>13</u> Year <u>1960</u> Hour <u>19</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Forest Hill</u>				(County) <u>Md.</u>		(State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>April 13, 1960</u> to <u>April 20, 1960</u> , that I last saw the deceased alive on <u>April 20, 1960</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Foo, M.D.</u>				ADDRESS (Street, city or town, state) <u>Harre de Grace, Md.</u>			
DATE SIGNED <u>4/20/60</u>							
PHYSICIAN'S NAME (Type) <u>Edward C. Foo, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>April 22, 1960</u>				22b. DATE THEREOF <u>April 22, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sheltonia Cem</u>	
22d. LOCATION (City, town, or county) <u>Hartford Co, Md.</u>				(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>				ADDRESS <u>Washington, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text follows, likely containing details of the deceased and the certifying officer.]

4617

CERTIFICATE OF DEATH

Reg. Dist. No.

04594

1. PLACE OF DEATH a. COUNTY <u>HARford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>HARford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X PERRYMAN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Mem. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>General Del.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Prince-Albert-Stansbury</u>				4. DATE OF DEATH Month Day Year <u>April 20 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct-10-1902</u>	9. AGE (In years lost birthday) <u>57</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm/Carving Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geo. Stansbury</u>				14. MOTHER'S MAIDEN NAME <u>Susan Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-03-8519</u>		INFORMANT Address <u>Olevia Stansbury - Box 156 Perryman Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of the Pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>157x</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>1/4</u> , 19 <u>60</u> , to <u>4/20</u> , 19 <u>60</u> that I last saw the deceased alive on <u>4/20</u> , 19 <u>60</u> , and that death occurred at <u>6:10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Stansbury</u>				ADDRESS (Street, city or town, state) <u>M.D. 569 Revolution St. Harrods Grace, Md.</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				DATE SIGNED <u>4/20/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen. Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Sarnung</u>			ADDRESS <u>Aberdeen, Maryland.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4603

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>				c. LENGTH OF STAY IN 1b <u>4 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>206 Hickory AVENUE</u>				d. STREET ADDRESS <u>206 Hickory AVENUE</u>			
3. NAME OF DECEASED (Type or print) First <u>Leah</u> Middle <u>L.</u> Last <u>Stehley</u>				4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3, 1885</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>HENRY LANTZ</u>				14. MOTHER'S MAIDEN NAME <u>GEORGIANA BARR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT (Daughter) <u>Mrs. Thelma Herbert</u> Address <u>206 Hickory AVENUE BEL AIR, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic CA TO VITAL ORGANS</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PRIMARY CA - UNKNOWN</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Progressive</u> <u>8 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PROFOUND CACHEXIA</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>				
20c. TIME OF INJURY Hour o. m. p. m. <u>—</u> 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10 April, 1960</u> , to <u>11 April, 1960</u> , that I last saw the deceased alive on <u>11 April - 2 AM</u> 19 <u>60</u> , and that death occurred at <u>5:20 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Warren R. Lesch, MD</u>				DATE SIGNED <u>115 Jefferson - Bel Air, MD 4/11/60</u>			
PHYSICIAN'S NAME (Type) <u>WARREN R. LESCH, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 14, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Altoona PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway + W. Filliams Street BEL AIR, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

199.2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4599

CERTIFICATE OF DEATH

Reg. Dist. No.

64596

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b 31			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 31 E. Bel Air Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EUNICE Middle JAMISON Last VIELE				4. DATE OF DEATH Month April Day 15 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1884	9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 6 Days 15 Hours 1 Min.		11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME David Jamison			
14. MOTHER'S MAIDEN NAME Mary Robinson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. *** ** *				17. INFORMANT Frederick J. Viele, Havre de Grace, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition 154X DUE TO Chronic Diarrhea Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Recurrent carcinoma, rectosigmoid DUE TO (c) 1 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 wk 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1950 to 1-15-60 , that I last saw the deceased alive on 1-15-60 , and that death occurred at 9:00 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED April 16, 1960							
ACTUAL SIGNATURE Peter P. Rodman, M.D.				PHYSICIAN'S NAME (Type) Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/60		22c. NAME OF CEMETERY OR CREMATORY Grove Cemetery		22d. LOCATION (City, town, or county) (State) Aberdeen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Tarring				24a. REC'D BY REGISTRAR APR 20 1960		24b. REGISTRAR'S SIGNATURE Carroll S. Tarring	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

109-1

4618

Item 13. See: Birth Cert. et

CERTIFICATE OF DEATH

64597

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>	
c. LENGTH OF STAY IN 1b <u>28 hrs.</u>		d. STREET ADDRESS <u>310 N. Stokes St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial H</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl WALLS</u>		4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/16/60</u>
9. AGE (In years lost birthday) yrs. <u>4</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>4</u> Hours <u>22</u> Min. <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Dean L. Barrett</u>		14. MOTHER'S MAIDEN NAME <u>Marian Lloyd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Marian Walls. 310 N. Stokes St.</u>	
17. INFORMANT <u>Marian Walls. 310 N. Stokes St.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>7605</u> (c) <u>7605</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7605</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>APRIL 17</u> , 19 <u>60</u> , and that death occurred at <u>5:32 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. J. Jones</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) _____ M.D. _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>4-18-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hartford Memorial Hospital</u>	22d. LOCATION (City, town, or county) (State) <u>Havre de Grace, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Tully Administrator</u>		24a. REC'D BY REGISTRAR <u>APR 22 '60</u>	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2071214xv1

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED (Print name in full)		2. SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
3. AGE (In years and months)		4. RACE (Print race)	
5. DATE OF DEATH (Month, day, year)		6. TIME OF DEATH (Hour, minute)	
7. PLACE OF DEATH (Print place)		8. CAUSE OF DEATH (Print cause)	
9. MANNER OF DEATH (Print manner)		10. SIGNATURE OF DECEASED (Print name)	
11. SIGNATURE OF WITNESS (Print name)		12. SIGNATURE OF DECEASED (Print name)	
13. SIGNATURE OF WITNESS (Print name)		14. SIGNATURE OF DECEASED (Print name)	
15. SIGNATURE OF WITNESS (Print name)		16. SIGNATURE OF DECEASED (Print name)	
17. SIGNATURE OF WITNESS (Print name)		18. SIGNATURE OF DECEASED (Print name)	
19. SIGNATURE OF WITNESS (Print name)		20. SIGNATURE OF DECEASED (Print name)	
21. SIGNATURE OF WITNESS (Print name)		22. SIGNATURE OF DECEASED (Print name)	
23. SIGNATURE OF WITNESS (Print name)		24. SIGNATURE OF DECEASED (Print name)	
25. SIGNATURE OF WITNESS (Print name)		26. SIGNATURE OF DECEASED (Print name)	
27. SIGNATURE OF WITNESS (Print name)		28. SIGNATURE OF DECEASED (Print name)	
29. SIGNATURE OF WITNESS (Print name)		30. SIGNATURE OF DECEASED (Print name)	
31. SIGNATURE OF WITNESS (Print name)		32. SIGNATURE OF DECEASED (Print name)	
33. SIGNATURE OF WITNESS (Print name)		34. SIGNATURE OF DECEASED (Print name)	
35. SIGNATURE OF WITNESS (Print name)		36. SIGNATURE OF DECEASED (Print name)	
37. SIGNATURE OF WITNESS (Print name)		38. SIGNATURE OF DECEASED (Print name)	
39. SIGNATURE OF WITNESS (Print name)		40. SIGNATURE OF DECEASED (Print name)	
41. SIGNATURE OF WITNESS (Print name)		42. SIGNATURE OF DECEASED (Print name)	
43. SIGNATURE OF WITNESS (Print name)		44. SIGNATURE OF DECEASED (Print name)	
45. SIGNATURE OF WITNESS (Print name)		46. SIGNATURE OF DECEASED (Print name)	
47. SIGNATURE OF WITNESS (Print name)		48. SIGNATURE OF DECEASED (Print name)	
49. SIGNATURE OF WITNESS (Print name)		50. SIGNATURE OF DECEASED (Print name)	
51. SIGNATURE OF WITNESS (Print name)		52. SIGNATURE OF DECEASED (Print name)	
53. SIGNATURE OF WITNESS (Print name)		54. SIGNATURE OF DECEASED (Print name)	
55. SIGNATURE OF WITNESS (Print name)		56. SIGNATURE OF DECEASED (Print name)	
57. SIGNATURE OF WITNESS (Print name)		58. SIGNATURE OF DECEASED (Print name)	
59. SIGNATURE OF WITNESS (Print name)		60. SIGNATURE OF DECEASED (Print name)	
61. SIGNATURE OF WITNESS (Print name)		62. SIGNATURE OF DECEASED (Print name)	
63. SIGNATURE OF WITNESS (Print name)		64. SIGNATURE OF DECEASED (Print name)	
65. SIGNATURE OF WITNESS (Print name)		66. SIGNATURE OF DECEASED (Print name)	
67. SIGNATURE OF WITNESS (Print name)		68. SIGNATURE OF DECEASED (Print name)	
69. SIGNATURE OF WITNESS (Print name)		70. SIGNATURE OF DECEASED (Print name)	
71. SIGNATURE OF WITNESS (Print name)		72. SIGNATURE OF DECEASED (Print name)	
73. SIGNATURE OF WITNESS (Print name)		74. SIGNATURE OF DECEASED (Print name)	
75. SIGNATURE OF WITNESS (Print name)		76. SIGNATURE OF DECEASED (Print name)	
77. SIGNATURE OF WITNESS (Print name)		78. SIGNATURE OF DECEASED (Print name)	
79. SIGNATURE OF WITNESS (Print name)		80. SIGNATURE OF DECEASED (Print name)	
81. SIGNATURE OF WITNESS (Print name)		82. SIGNATURE OF DECEASED (Print name)	
83. SIGNATURE OF WITNESS (Print name)		84. SIGNATURE OF DECEASED (Print name)	
85. SIGNATURE OF WITNESS (Print name)		86. SIGNATURE OF DECEASED (Print name)	
87. SIGNATURE OF WITNESS (Print name)		88. SIGNATURE OF DECEASED (Print name)	
89. SIGNATURE OF WITNESS (Print name)		90. SIGNATURE OF DECEASED (Print name)	
91. SIGNATURE OF WITNESS (Print name)		92. SIGNATURE OF DECEASED (Print name)	
93. SIGNATURE OF WITNESS (Print name)		94. SIGNATURE OF DECEASED (Print name)	
95. SIGNATURE OF WITNESS (Print name)		96. SIGNATURE OF DECEASED (Print name)	
97. SIGNATURE OF WITNESS (Print name)		98. SIGNATURE OF DECEASED (Print name)	
99. SIGNATURE OF WITNESS (Print name)		100. SIGNATURE OF DECEASED (Print name)	

4619

CERTIFICATE OF DEATH

04598

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Vigne</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hosp.</u>				d. STREET ADDRESS <u>Box 425 J Rt. #1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Sawyer</u> Last <u>Walter</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2, 1896</u>		9. AGE (In years lost birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>N. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Robert Lee Walters -</u>				14. MOTHER'S MAIDEN NAME <u>Callie Gene Hudson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes.</u> <u>W.W. I</u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>R. Glenn Walter</u> Address <u>Fallston Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr. hypertensive cardio-vascular disease.</u> DUE TO (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 3,</u> 19 <u>59</u> , to <u>April 24,</u> 19 <u>60</u> that I last saw the deceased alive on <u>23 April</u> , 19 <u>60</u> , and that death occurred at <u>8:14 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u> DATE SIGNED <u>April 25, 1960</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John</u>		22d. LOCATION (City, town, or county) (State) <u>Fountain Green Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Rutz</u> ADDRESS <u>Garrettsville Md</u>				24a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

4620

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. LENGTH OF STAY IN 1b <u>72 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>Stafford Road</u>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Harrison</u> Last <u>White</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OF RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 4, 1888</u>	
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>George White</u>				14. MOTHER'S MAIDEN NAME <u>Sarah O. GATES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>717-07-5724</u>			
INFORMANT <u>—</u> Address <u>—</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE Coronary Thrombosis</u> <u>420.1</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>1947</u> , 19 <u>—</u> , to <u>APRIL 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>APRIL 2</u> , 19 <u>60</u> , and that death occurred at <u>11:50 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dudley Phillips</u> M.D. <u>DARLINGTON MD</u>				DATE SIGNED <u>4/2/60</u>			
PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-5-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DARLINGTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HARFORD MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Madison Mitchell</u> ADDRESS <u>HAVREDE GRACE MD.</u>				24a. REC'D BY REGISTRAR <u>APR 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2 1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64600
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Reading</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reading</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Smith Chapel Methodist Church</u>		d. STREET ADDRESS <u>520 S. 17th. Street</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Yez</u> Last <u>Yez</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/27/1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Blazey Yez</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>160-18-7930</u>	
17. INFORMANT <u>Robert Beekley, Havre de Grace #2, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <u>A</u>		DATE SIGNED <u>4-26-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4/26/60</u>	
22c. NAME OF (CEMETERY) OR CREMATORY <u>St. Stephens Polish</u>		22d. LOCATION (City, town, or county) (State) <u>Reading Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Tarring</u>		ADDRESS <u>Aberdeen, Md</u>	
Tarring Funeral Home		REC'D BY REGISTRAR DATE <u>APR 29 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			

